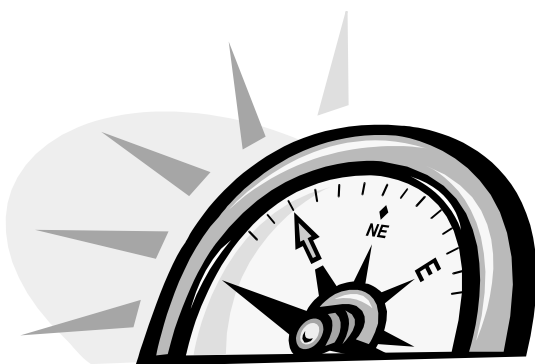


# *A Guide to Your*

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## EXPLANATION OF BENEFITS



**BlueCross BlueShield  
of North Dakota**

***NORIDIAN***<sup>®</sup>  
*Mutual Insurance Company*<sup>\*</sup>

<sup>\*</sup>*An Independent Licensee of the Blue Cross and Blue Shield Association*


<sup>®</sup> *Registered marks of the Blue Cross and Blue Shield Association*

<sup>®</sup> *Registered mark of Noridian Mutual Insurance Company*

# EXPLANATION OF BENEFITS

This form has been designed to explain how your health care claims were processed. The major features of the EOB include:

- 1 **Addresses** - The mailing address and website for BCBSND.
- 2 **This Is Not A Bill** - Please do not send payment for this service to BCBSND. Please keep this form for your records.
- 3 **Subscriber's Name and Address** - The name and address of the subscriber as shown on our records. If not correct, please call customer service at the numbers shown on the back of your ID card or on your EOB form.
- 4 **Date** - Date the EOB is printed.  
**Benefit Plan Number** - The subscriber's BCBSND benefit plan number.  
**Page Number** - Identifies the number of pages for this EOB.
- 5 **Customer Service Phone Numbers** - The numbers you should call with questions on this EOB.
- 6 **Patient/Claim Number** - The name of the patient who received the service and the claim number designated for the purpose of identification.
- 7 **Paid To** - The name of the individual or institution that was paid for the service.
- 8 **Total Charge** - The total charge associated with the claim.
- 9 **Covered Amount** - The portion of the claim that has been discounted or paid by this plan.
- 10 **Previously Processed** - Any amount previously processed by this plan, Medicare or another insurance company.
- 11 **Your Responsibility** - The portion of the claim that you are responsible to pay to your provider.
- 12 **Your Responsibility To The Provider** - The total amount that you are responsible to pay to your provider.




4510 13TH AVENUE S.W.  
FARGO, NORTH DAKOTA 58121-0001  
WWW.NORDIAN.COM

**2 THIS IS NOT A BILL**  
(Please Keep This Form For Your Records)

**3** DOE JOHN A  
1234 ANYWHERE DRIVE  
FARGO ND 58103

**4** Date: 07/23/99  
Benefit Plan Number: VQA999999999  
Page Number: 1 of 2



### EXPLANATION OF BENEFITS

**5** Customer Service  
Local: 701-999-9999  
Toll Free: 800-999-9999

<b>6</b> Patient/Claim Number	<b>7</b> Paid to :	<b>8</b> Total Charge	<b>9</b> Covered Amount	<b>10</b> Previously Processed	<b>11</b> Your Responsibility
JUDY 9920100000/00	FORT PECK SERVICE	128.00	88.00	0.00	40.00

**12** \* YOUR RESPONSIBILITY TO THE PROVIDER: 40.00

\* This Explanation of Benefits (EOB) does not reflect any payments you may have made to the provider. Also, this EOB does not reflect any payment that may have been made to you or the provider by Medicare or another insurance carrier.

For information about your right to appeal, please call or write our customer service department at the above telephone number or address on this explanation of benefits form.

**13** YEAR TO DATE COST SHARING STATUS : 1999

Applied to \$400 per member deductible:	Applied to \$1200 per member coinsurance:
JOHN \$ 400.00 JANE \$ 29.00	JOHN \$ 1200.00 JANE \$ .00
JUDY \$ 371.00	JUDY \$ 344.92
\$ 800.00 has accumulated toward family deductible maximum.	\$ 1544.92 has accumulated toward family coinsurance maximum.

**14** IMPORTANT MESSAGE:  
Health care services received outside Blue Cross Blue Shield of North Dakota's service area are eligible for processing through the Out-of-Area Program with other Blue Cross Blue Shield Plans. Claims incurred nationwide at any Blue Cross Blue Shield participating provider and processed through the Out-Of-Area program may save you money and minimize your filing requirements.

**15** FOR BREAKDOWN OF CHARGES AND BENEFITS ... SEE BACK >>>

- 13 **Year To Date Cost Sharing Status** - The total deductible, coinsurance, and/or copayment that you and/or your family members have accumulated to date. These totals may reflect claims in process for which you have not yet received an EOB. Only family members who have accumulated cost share will be listed.
- 14 **Important Message** - This space has been reserved for general messages that may apply to you.
- 15 **For Breakdown Of Charges And Benefits** - A detailed breakdown of how your claims were processed is included on the reverse side of your EOB.

# BREAKDOWN OF CHARGES AND BENEFITS

<b>16</b> Date: 07/23/99	DOE JOHN A		Benefit Plan Number: YQA999999999		Group: 999999		Page 1 of 2				
<b>17</b> Patient/Claim Number	<b>18</b> Provider/Type of Service	<b>19</b> Processed Date	<b>20</b> Date of Service	<b>21</b> Charges Submitted	<b>22</b> Provider Discount	<b>23</b> Blue Cross Blue Shield	<b>24</b> Previously Processed	<b>25</b> Noncovered Charges	<b>26</b> Deductible	<b>27</b> Coinsurance	<b>28</b> Copayment
JUDY / Claim 9920100000/00	PORT PECK SERVICE / Office Medical Care	07/27/99	06/17/99	128.00		88.00		18.00 A		22.00 B	
<b>TOTALS:</b>				128.00		88.00		18.00		22.00	

## EXPLANATION OF NOTES:

A - This amount over the Blue Cross Blue Shield of North Dakota allowance is the subscriber's responsibility. (06-002-03)

B - Benefits are provided for 80% of the Blue Cross Blue Shield of North Dakota allowance for this service. You are responsible for payment of the remaining 20% coinsurance. (09-002-20)

\* YOUR RESPONSIBILITY TO THE PROVIDER: 40.00

- 16** **Date** - Date the EOB was printed.
- 17** **Name** - Subscriber's name.
- 18** **Benefit Plan Number** - The subscriber's BCBSND benefit plan number.
- 19** **Group Number** - The subscriber's health insurance plan group number.
- 20** **Patient/Claim Number** - The name of the patient who received the service and the claim number designated for the purpose of identification.
- 21** **Provider/Type of Service** - The name of the individual or institution that performed the service and the type of service that was performed.
- 22** **Processed Date** - The date the claim completed processing.
- 23** **Date of Service** - The date the service was performed.
- 24** **Charges Submitted** - The charge billed by your provider for each service.
- 25** **Provider Discount** - The portion of the charge that may have been discounted by your provider.
- 26** **Blue Cross Blue Shield** - The amount the subscriber's coverage paid toward each service.
- 27** **Previously Processed** - Any amount previously processed by this plan, Medicare or another insurance company.
- 28** **Noncovered Charges** - The charges that are noncovered according to the terms set forth in your benefit plan.
- 29** **Deductible** - Specified dollar amount for certain covered services received during the benefit period that is your responsibility to the provider.
- 30** **Coinsurance** - Percentage of the allowed charge for certain covered services that is your responsibility to the provider.
- 31** **Copayment** - Specified dollar amount payable for certain covered services that is your responsibility to the provider.
- 32** **Your Responsibility To The Provider** - The total amount that you are responsible to pay to your provider.
- 33** **Explanation Of Notes** - Explanations or descriptions corresponding to the amount(s) noted in the breakdown of charges and benefits (sections 23, 25, 26, 27, 28 and 29 shown above).



**Please call customer service with any questions. The phone numbers are listed on the front of your EOB or on the back of your ID card.**

